OFFICE & PRIVACY POLICY

ELITE SPINE Chiropractic
20 Creekview Court Ste. B
Greenville, SC 29615

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially, to determine if their spine is developing abnormally! A spinal check–up is easy and fun for kids.

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great! ☺ _____ **initials**

PRIVACY POLICIES:

- Our office will safeguard your personal health information and will not release or use it without your written permission except where allowed or directed by law. Your information is not released or sold to outside sources. If you have health insurance, we provide the service of electronically filing those claims for you. _____ **initials**

- I authorize Dominic Lupori, DC or ELITE SPINE Chiropractic, LLC to release any information in order to process insurance claims on my behalf. I understand my insurance may or may not have any benefits for chiropractic services and those benefits are determined by the policy I have chosen. I further understand that my insurance and I have entered an agreement and that does NOT include this office or the doctor at this office. _____ **initials**

- I understand that this office may need to contact me. I authorize ELITE SPINE Chiropractic, LLC to leave a message, text or email me at the contact information provided below. I understand I can restrict where these messages go and how they are sent in writing. _____ **initials**

- I understand that this office may send seasonal, birthday cards or other invitations for promotions or events. I agree to receive these mailings. I may restrict this in writing. _____ **initials**

- I understand that this office may utilize my name, photo, video or testimonial during the normal course of business. I understand I may restrict any and all of these uses at anytime in writing. _____ **initials**

- I consent to have a family member or designated individual present during my care, which may include, exams, reports, adjustments or other services. I understand that I can limit and restrict to whom information is released._____ **initials**

- I understand that I am responsible for all charges for services rendered to me in this office. I understand that payment is due and expected at the time services are rendered. _____ **initials**

This is notice of our privacy policies. You have the right to revoke your agreement to these policies at any time in writing. Your signature here is your agreement, authorization and consent to the above policies. A copy of these policies is available for your convenience.

Patient Name _____ Patient Signature_____
Date_____ Primary Phone Number ( )_____-_____Email Address_____

Spousal Consent or Parental Consent I give consent to have my information regarding appointments, report of findings and financial information released to my spouse or parent.

Spouse or Parent Name _____ Name _____
Relation to Patient_____